Exhibit R
Walker Baptist Medical Center Records dated 11/11/02

52

WALKER BAPTIST MEDICAL CENTER

EMERGENCY PHYSICIAN RECORD
Psych Disorder, Suicide Attempt, Overdose (5)

BARRON TOMMY
SOUTHERN MEDICAL GRO 11/11/02
MR: 0246796 M W 045 [redacted]
PT: 9539218-9 CAE ED 02 L

TIME SEEN: 2140 ROOM: _____ EMS Arrival

HISTORIAN: patient spouse paramedics _____
AGE _____ M / F _____

__HX / __EXAM LIMITED BY: _____

HPI chief complaint(s):

Suicidal Thoughts Depression Suicide Attempt
Agitated Hallucinating
Self-Injury
Intentional Drug Overdose
Accidental Drug Ingestion

Onset: attempted to shoot himself - shotgun
Worsened since: (he is trying) - blew most to upper left of head -
When? _____
Cardiac AD

severity:
mild moderate severe

context: unknown

__situational problems
related to: spouse / parent / son / daughter / significant other
work / lost job / school / legal problems

current/associated complaints:
__depressed / angry / frustrated / agitated / hostile / paranoid

__confused / hallucinating

__suicidal thoughts / specific plan / gesture or attempt

__ingestion (see list below)
suicide attempt *wanted to "escape"* *accidental* *will not answer*

__incised / abraded wrist (R / L)

timing

LIST OF SUBSTANCES INGESTED (*if applicable*)

name	strength	# taken	when taken
acetaminophen Y / N			
aspirin Y / N			
ethanol Y N		Co-tox	

"RESCUE FACTOR" (if suicide attempt)-
How did ingestion/other acts come to attention?

Arrived by: __private car __ambulance (who called?)
__police *patient* *spouse* _____
__Recently seen/treated by doctor

ROS

PULMONARY & CVS
__cough
__trouble breathing
__chest pain

NEURO & EYES
__headache
__visual disturbance

GI - GU
__abdominal pain
__nausea
__vomiting
__diarrhea
__problems urinating

SKIN & LYMPH & MS
__skin rash / swelling
__joint pain

☐ all systems neg. except as marked

PAST HISTORY __negative See nurses note

__prior suicide attempt
__psychiatric problems
depression *bipolar disorder*
schizophrenia *other*

__cardiac disease
__hypertension
__diabetes *insulin / oral / diet*
__lung disease
__+HIV / AIDS

__other problems

Surgeries:
__tonsillectomy N/C __appendectomy
__cholecystectomy __hysterectomy

Medications __none see nurses note

Allergies __NKDA
see nurses note

SOCIAL HX smoker drugs
recent alcohol use / binge drinking / alcoholism
marital status: __single __married children:

☐ Nursing Assessment Reviewed. ☑ BP, HR, RR, Temp reviewed.

PHYSICAL EXAM __Alert ☑Lethargic __Obtunded
Distress __NAD __mild __moderate __severe
__uncooperative for exam _____

HEENT
__nml ENT inspection
__pharynx nml
if obtunded:
__nml gag reflex
__depressed / absent gag reflex_____
__abnormal TM (R / L)_____
__dry mucosa_____
_____
__gag reflexed diminished / absent_____

EYES
☑pupils equal, round & reactive to light
☑EOM's intact
__nystagmus_____
__disconjugate gaze_____
__mydriasis / meiosis / anisocoria_____
R Pupil _____*mm* *L Pupil* _____*mm*

NEURO/PSYCH
mental status
__mood/affect nml
__slow / no response to commands_____
withdraws to pain *no response to pain*
depressed affect
tearful/ hostile / non-communicative
__suicidal ideation_____

For suicide attempts: On direct query, patient *ADMITS / DENIES* continued consideration of suicide as an option.
If denies, why? _____

orientation
__normal x3
__uncooperative / cannot determine_____
__disoriented_____
to: *day-of-week* *day-of-month* *month* *year* *place* *person*

cranial nerves
sensory, motor
__CN's intact as tested
__nml motor response
__nml sensory response
__nml reflexes
__nml gait
__facial droop / CN abnormality_____
__motor/sensory deficit_____
_____
__abnormal gait_____
_____

NECK/BACK
__normal inspection
__neck supple
__cerv. lymphadenopathy (R / L)_____
__thyromegaly / meningismus_____
FROM

RESPIRATORY
__no resp. distress
__breath sounds nml
__wheezing_____
__rales / rhonchi_____

CVS
__regular rate, rhythm
__heart sounds normal
__irregularly irregular rhythm_____
__extrasystoles (occasional / frequent)
__tachycardia / bradycardia
__JVD_____

ABDOMEN
__non-tender
__nml bowel sounds
__no organomegaly
__guarding_____
__hepatomegaly / splenomegaly_____

SKIN
__color nml; no rash
__warm, dry
__cyanosis / diaphoresis / pallor_____
__skin rash_____

EXTREMITIES
__non-tender
__normal ROM
__no signs of injury
__no pedal edema
__laceration_____
__pedal edema_____

PROCEDURES: ☐ Restraints
☐ Intubated __by ED physician nasal /oral #____ET tube
__breath sounds equal __ tube position confirmed w CXR
☐ Gastric Lavage __*pill fragments recovered*
☐ Charcoal _____gm given Sorbitol _____oz given

LABS, XRAYS, and PROGRESS

EKG MONITOR STRIP __NSR __Rate_____

EKG __*NML* ☐Interp. by me. ☐Reviewed by me Rate_____
__*NSR* __*nml intervals* __*nml axis* __*nml QRS* __*nml ST/T*
not / *changed from:*_____

CXR ☐Interp. by me ☐Reviewed by me ☐Discsd w/radiologist.
__*nml/NAD* __*no infiltrates* __*nml heart size* __*nml mediastinum*
not / *changed from:*_____

CBC *normal except*	**Chemistries** *normal except*	**ABG's** time:	**Toxicology** *normal except*
WBC_____	Na_____	_____	acetamin._____
Hgb_____	K_____		aspirin-_____
Hct_____	Cl_____	pH_____	ETOH-_____
Platelets_____	CO2_____	pCO2_____	
segs_____	BUN_____	pO2_____	Triage™ urine drug screen-
bands_____	Creat_____	__RA	_____
lymphs_____	Gluc_____	__O2 ____L	_____
monos_____	Anion Gap_____		

Pulse Ox _____% on *RA* / ____*L* / ____% *at (time)*_____

*Time*_____ __unchanged __improved __re-examined_____
EKL 28

__Rx given_____

INTERVIEW WITH OTHER RESPONSIBLE ADULT:
*Name:*_____ *Relationship:* _____
Considers ongoing suicide risk: *high* *low* *uncertain*
Capable / comfortable with observing patient at home? *Yes* *No* *N/A*

MEDICAL CLEARANCE FOR PSYCHIATRIC REFERRAL (if needed)
Back-slash to indicate that diagnosis is unlikely based on H&P and, when needed, lab testing.
- Toxic (PCP, Amphetamines, Hallucinogens, Acetaminophen, ASA, ETOH, Other)
- Infectious (Meningitis, Encephalitis, Sepsis)
- Metabolic (Thyroid, Hypoglycemia, Drug Withdrawal, Hypoxemia, Electrolytes)
- CNS Vascular and Other (CVA, TIA, Seizure, Trauma)
- Other Unstable Comorbidities ☐cleared medically for psych referral

__Discussed with Dr._____
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results *diagnosis* *need for follow-up*
__Admit orders written
__CRIT CARE- *30-74 min* *75-104 min* _____ *min*
__Prior records ordered
__Additional history from: *family* *caretaker* *paramedics*

CLINICAL IMPRESSION:

Ethanol Intoxication
Depression *major* *manic*
Psychosis Schizophrenia- *acute exac.*
Drug Overdose(Intentional/ accidental)
Suicide Attempt/ Ideation

Discharge Instructions _____

DISPOSITION- ☐ home ☑ admitted ☐ transfer _____
CONDITION- ☐ unchanged ☐ improved ☐ stable _____

_____ *NP / PA*
_____ *MD / DO*

I have personally performed and participated in all the above services (including HPI and PE) and procedures. I have reviewed with the PA/NP the history and have confirmed the findings with the patient.

☑ Template complete ☐ Progress Notes

WALKER
BAPTIST MEDICAL CENTER

EMERGENCY DEPARTMENT RECORD

PATIENT NO	DATE	TIME	CLINIC 1	VERIFIED BY	ROOM NO	TYPE	F/C	SPECIALTY	CLERK
9539218-9	11/11/02	21:42	ERRM		ED 02	E	L		CAE

AGE	BIRTHDATE	SEX	RACE	M/S	MOTHER'S MAIDEN NAME	SOCIAL SECURITY NO	PHONE	COUNTY	MED. REC. NO.
045	[redacted]	M	W	M	HAGOOD	[redacted]	[redacted]	WALKER	0246796

PATIENT NAME & ADDRESS
BARRON TOMMY
[redacted]

LAST VISIT DATE & TYPE: 11/07/02 INPT1
ACCIDENT DATE/CAUSE: 11/11/02 PT STATES "
W/C CONTACT:
AUTH NO:
ARRIVED VIA: AMBULANCE-OT
RECEIPT NO. & AMT:

GUARANTOR NAME & ADDRESS
BARRON, TOMMY
[redacted]
SOC. SEC. NO. [redacted]
PHONE [redacted]

EMPLOYMENT INFORMATION - ONE
REL
SOCIAL SECURITY #
PHONE
STAT

EMPLOYMENT INFORMATION - TWO
REL 02SPOUSE
SOCIAL SECURITY # [redacted]
PHONE
STAT 7

IN CASE OF EMERGENCY CONTACT (NAME & ADDRESS)
DIANE MCCULLEN/[redacted]
JAN EDWARDS [redacted]
RELATIONSHIP
PHONE

PHYSICIANS' NUMBERS AND NAMES
1 999995 SOUTHERN MEDICAL GRO
2
3 000000 NO FAMILY PHYSICIAN
PCP PHYSICIAN

1. INSURANCE CODE & NAME: 1M60MEDICARE OUTPT
POLICY NO: [redacted]
PRECERTIFICATION NO.
SUBSCRIBER NAME & BIRTHDATE: BARRON ,TOMMY
GROUP NO.

2. INSURANCE CODE & NAME: 2K28MEDICAID 2NDA
POLICY NO: [redacted]
PRECERTIFICATION NO.
SUBSCRIBER NAME & BIRTHDATE: BARRON ,TO
GROUP NO.

3. INSURANCE CODE & NAME
POLICY NO.
PRECERTIFICATION NO.
SUBSCRIBER NAME & BIRTHDATE
GROUP NO.

4. INSURANCE CODE & NAME
POLICY NO
PRECERTIFICATION NO.
SUBSCRIBER NAME & BIRTHDATE
GROUP NO.

CHIEF COMPLAINT: MEDICAL
CODES
COMMENTS

RESULTS
Monitor
EKG
Radiology
Laboratory
Other

Time Examining MD Notified: _____ Time Patient Examined: _____
Condition on Arrival: ☐ Satisf. ☐ Fair ☐ Poor ☐ Critical
Chief Complaint:
HPI

Provisional Diagnosis:

Disposition Time: ☐ Discharged ☐ Admitted ☐ Transferred ☐ AMA
Condition On Discharge: ☐ Satisf. ☐ Fair ☐ Improved ☐ Poor ☐ Critical
Certified Emergency: ☐ Yes ☐ No

CONSULT	TIME NOTIFIED	RESPONDED	ARRIVED

_____ M.D.
Examining M.D. Signature

WALKER
BAPTIST MEDICAL CENTER

DISCHARGE INSTRUCTIONS

NAME BARRON TOMMY DATE 11/11/02 PT # 9539218-9

Discharge Instructions
Given to Patient

Fever	Back Pain
Head Injury	Sprain/Strain
Cast/Splint	Vomiting/Diarrhea
Wound Care	UTI
Crutch Training	Food/Drug Interaction

Other _____

1. Return if worse. 2. Read instruction sheet.
3. Have prescription(s) filled as soon as possible.
4. Special instructions: _____
5. Medication received in ER may hinder your ability to operate any vehicle or other type of machinery.
6. You should see Dr. _____ in _____ days.
   You should see Dr. _____ in _____ days.
   Call for appointment, phone number _____

Examination and treatment you have received in the Emergency Department is given as emergency care only. It is not indended to be a substitute for complete medical care. X-ray impressions made in the Emergency Department are subject to review. If the review indicates additional information, you or your physician will be contacted.

I acknowledge that I have received and understand these instructions.

Patient Signature _____ Date _____ Time _____

Nurse Signature _____

SCHOOL / WORK EXCUSE

WALKER
BAPTIST MEDICAL CENTER

Date 11/11/02 Patient Name BARRON TOMMY

May Return to Work / School Date _____

Restrictions: ☐ None ☐ Other _____

MD Signature _____

WALKER
BAPTIST MEDICAL CENTER

Name BARRON TOMMY Date 11/11/02
1012 N W 6TH STREET

Address CARBON HILL AL 355495002

MEDICINE PRESCRIBED

MEDICINE	SIG	DISP	REFILL

Fill All Medicines Prescribed

DISPENSE AS WRITTEN _____ MD DEA NO. _____

PROD. SELECTION PERMITTED _____ MD LICENSE NO. _____

BARRON TOMMY
SOUTHERN MEDICAL GRO 11/11/02
MR: 0246796 M W 045 [redacted]
PT: 9539218-9 CAE ED 02 L

PATIENT STATUS

A. PATIENT ADMITTED**DO NOT DISCHARGE**

1413

1 DIED

2 LAMA(LEFT AGAINST MEDICAL ADVICE)

3 TRANSFERRED

4 DISCHARGED

5 LEFT BEFORE SEEN

6 BMC NOT INSURANCE PROVIDER

Bentley

Depressive Disorder
Alcohol Intoxication

PHYSICIAN Simmons

DISCHARGE TIME

CERTIFIED EMERGENCY YES OR NO

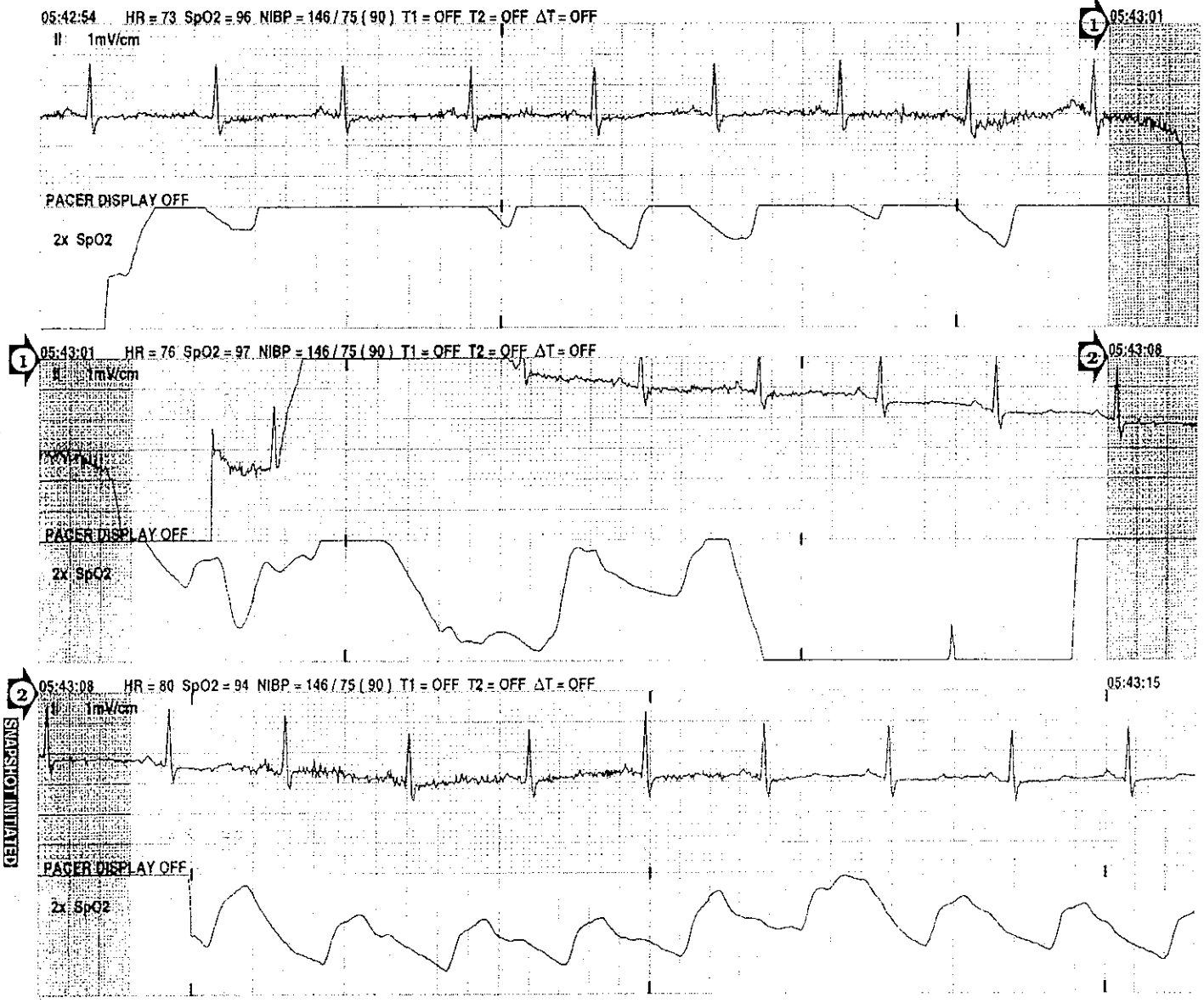
MEDICAID ONLY)

CO-PAY OR EMERGENCY DEPARTMENT FEE DUE
AT END OF VISIT

Tuesday 12-November-2002 05:42:54 **Walker Baptist Medical Center**

MARY BLACKMON	9539237-9	ED 16

SNAPSHOT 25 mm/sec Adult/Pediatric



Vital Signs Summary			
Time	Sys / Dia (Mean)	HR/PR	SpO2
HH:MM	-- mmHg (NIBP) --	BPM	%
05:15	145 / 74 (90)	65	98
05:20	165 / 80 (96)	67	99
05:25	138 / 77 (96)	70	98
05:30	143 / 81 (96)	89	100
05:35	136 / 74 (84)	74	100
05:40	146 / 75 (90)	70	97

Comments

WALKER BAPTIST MEDICAL CENTER OBS

Emergency Department
ORDER FORM

BARRON TOMMY
SOUTHERN MEDICAL GRO 11/11/02
MR: 0246796 M W 045 [redacted]
PT: 9539218-9 CAE ED 02 L
OBS

MEDICATION / TREATMENT / RESPONSE

TIME	MEDICATION / TREATMENT	DOSE	ROUTE	SITE	INITIAL	TIME	PATIENT RESPONSE	INITIAL
0210	Ativan	2.5mg	po	po	RC	(per pt's own medicine		
0430	Tylenol	1gm	po	po	R	v.o. Dr Simmons)		

MD ORDERS

TIME	MD ORDERS
2335	Recheck Blood alcohol at 0300 RC

Blood to lab 0300

TD 0.5 MI IM EXP/Lot No.

INTERVENTIONS/ORDERS

☐ B/P Monitoring ☐ IV ☐ Hep Lock
☐ Oxygen ☐ Pulse OX ☐ Telemetry

LABORATORY

ORDERED / COMPLETED — TEST

☐ CBC WBC____ HGB____ PLT. CT.____
HCT____ SEG____ B____
☐ Cardiac Enzymes: CK____ MB____ CKMB%____
☐ Troponin____ ☐ CPK____
☐ PT____ PTT____ INR____
☐ BMP: Na____ K____ Cl____ CO2____ BUN____
Creat____ AG____ Glucose____ Ca____ Osmo____
☐ CMP: BMP (Above) + Hepatic Function Panel (Below)
☐ Hepatic Function Panel Albumin____ Total Protein____
Bilirubin____ Bili Direct.____ Alk. Phos.____ SGOT____ SGGT
☐ Amylase:____ ☐ Lipase:____
☐ Theophylline:____ ☐ Dilantin:____
☐ Digoxin:____ ☐ Phenobarb:____
☐ UA: SPGR____ WBC____ RBC____ Gluc____ Ket____ Bact____ Nitrate____
☑ Urine Culture: ☐ Cath ☐ CCU ☐ Urine Pregnancy
☑ Urine Drug Screen ① ☐ ETOH____
☐ Serum Pregnancy ☐ Neg ☐ Pos ☐ Quant
☐ Rapid Strep____ ☐ Throat Culture ☐ Mono Spot
☐ Blood Culture
☐ Etoh ②
☐

DH 2218

VITAL SIGNS

TIME	TEMP	PULSE	RESP.	B/P	PULSE OXIMETRY	NURSE SIGNATURE/TITLE
0235	—	115	20	172/106		R Cooper
0450		92	20	14/77		Johnson

See Vital Signs Flow Sheet

RADIOLOGY

Time To ____ Time From ____

IV FLUIDS

TIME	NO	TYPE	AMT	RATE	CATH	ROUTE/LOC	NO. OF STICKS	NURSE INIT

RESPIRATORY

☐ ABG PH____ CO2____ PO2____ SAT____
☐ Breathing Treatment: Medication____
☐ EKG ☐ NSR Rate____ ☐ ABNL____
☐

NURSE DISCHARGE CHECKLIST: ☐ Tetanus Given ☐ IV Site Checked ☒ Valuables Checklist ☐ Antibiotic Given

CERTIFIED EMERGENCY: ☑ YES ☐ NO
DIAGNOSIS: ☐ SEE T-SHEET OTHER: ____
DISPOSITION: ☐ ~~Discharged~~ ☐ 23 Hr. Obs. ☐ Admit to Rm./Unit 1417 ☐ Report to/Time: 1850 ____
☐ Transfer to Hosp./Fac.: ____ ☐ AMA

METHOD OF LEAVING ED: ☒ Ambulatory ☐ Stretcher ☐ Wheelchair ☐ Crutches ☐ Carried ☐ Amb./Helicopter

☐ OBSERVATION: @ Time ____ ☐ Chest Pain Bed ☐ Stroke Bed ☐ Critical Care Bed ☐ ICU - Bed ☐ Other: ____

DISCHARGE INSTRUCTIONS: ____

☐ Return to Emergency Department as Needed ☐ F/U with MD in ____ or if needed.

CONDITION AT DISCHARGE: ☐ GOOD ☐ POOR ☐ FAIR ☐ DECEASED

PATIENT D/C INSTRUCTIONS GIVEN: ☐ Head Injury Sheet ☐ Wound Sheet ☐ Fever Sheet
☐ Crutch Precautions ☐ Sprain/Bruise Sheet ☐ Eye Patch Sheet ☐ Clear Liquid Sheet ☐ TAB Sheet
☐ Instructed Not to Drive Due to Sedation ☐ Instructed to Wait 15 Minutes After Injection / PO MED
☐ RX ☐ Written Patient Instructions ☒ See Nurse's Notes DISCHARGE TIME: 0600

Physician's Signature: ____
Discharge Nurse Signature: Cooper

REV 4/01 WBMC 6300-03-PG/C-122041

BARRON TOMMY
SOUTHERN MEDICAL GRO 11/11/02 [redacted]
MR: 0246796 M W 045
PT: 9539218-9 CAE ED 02 L

WALKER BAPTIST MEDICAL CENTER

EMERGENCY DEPARTMENT RECORD

PATIENT NO.	DATE	TIME	CLINIC	VERIFIED BY	ROOM NO.	TYPE	F/C	SPECIALTY	CLERK
9539218-9	11/11/02	21:42	ERRM		ED 02	E	L		CAE

VITAL SIGNS / **ORTHOSTATIC VITAL SIGNS**

TIME	T	P	R	BP	BP	P	BP	P	O2 SAT / FIO2

MONITOR
Cardiac ___ Fast Patch ___ Pacer Pads ___ Pulse Ox ___ NIBP ___

TREATMENT:
O2 Device ___ FIO2 ___ ET Tube ___ CO2 DET ___ Tube Tamer ___ Stylette ___ Suction ___ Yankauer ___ Control Tip ___ Oral Airway ___ Nasal Airway ___ NG Tube ___ Lavacuator ___ Foley ___ OCL ___ IN ___ FT ___ Emesis Bag ___ Sterile 4x4's ___ Betadine Soak ___ Pencil Cautery ___ Other ___

Eye Tray ___ Irrigation Sol ___ Morgan Lens ___ Ear Tray ___ Chest Tube Tray ___ Chest Tube ___ Blade ___ Suture ___ Xylocaine ___ Thoraseal ___ Trach Tray ___ Trach Tube ___ Vein Cutdown ___ Triple Lumen ___ Percut Introducer ___ Open Chest ___ Peritoneal Lavage ___ Other ___

NURSE'S NOTES

TIME	NURSE'S NOTES
2226	Urine given
2233	UA specimen collected
	Sent to lab
2300	Pt Out to smoke
	c Security
2350	pt unable to sleep
	after being moved
	to Exam 2 pt taken
	back to OBS room
	monitor on — RC
0030	pt out c Security
	Smoking — RC
0230	pt out c Security
0240	pt c/o HA v.o. ~~[illegible]~~ Ultram
	~~[illegible]~~ po v.o. Dr. Simmons
0340	pt c/o needing to smoke
	pt Smoking — RC
0540	pt resting quietly c
	no complaints — RC

IV FLUIDS

TIME	#	TYPE	AMT	RATE	CATH	SITE	INIT

MD ORDERS

TIME ORDERED		TIME DONE/INIT

ADVERSE REACTION TO MEDICATION ☐ Yes ☐ No
RX WITH WARNING GIVEN ☐ Yes ☐ No

☐ Admitted ☐ Discharged ☐ Transferred
Nurse Report Called To: Time

Patient Condition on Discharge ☐ Stable ☐ Improved ☐ Unchanged
Time Discharged

RN Signature
1 [signature]
2 R Coaley

EMERGENCY DEPT. TRIAGE FORM

TRIAGE NAME: Barron, Tommy | AGE: 45 | DATE: 11/11/02

BARRON **TOMMY**
SOUTHERN MEDICAL GRO 11/11/02
MR:**0246796** M W 045 [redacted]
PT: **9539218-9** CAE ED 02 L

ROOM #	TIME IN ROOM	EMERG.	URGENT	SEMI-URGENT	NON-URGENT	RECHECK ☐ Scheduled ☐ Non-Scheduled

ACCOMPANIED ON ARRIVAL BY: ☒ SELF ☐ RELATIVE ☐ OTHER
☐ TRANSFER FROM _____ HOSP.
NOTIFIED: Police ☐ Family ☐ Coroner ☐ Time: _____

MODE OF ARRIVAL: ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ POLICE ☐ OTHER
☐ AMBULATORY ☐ WHEELCHAIR ☐ CARRIED ☐ CRUTCHES ☒ STRETCHER

FAMILY M.D.: Bentley | SIGN IN TIME: 2135
Have you seen an M.D. in the last 24 hours? Y ☐ N ☐ | Call Light ☐ | Side Rail Up ☐ | Valuables ☐ Y ☐ N ☐ See Valuables Checklist

AREA ☐ MAIN ED: ☒ TRAUMA ☐ Major ☐ Minor ☒ MEDICAL ☐ Cardiac ☒ Non-Cardiac ☐ FAST TRACK: ☐ GYN ☐ EENT ☐ ORTHO ☐ Other _____

CHIEF COMPLAINT Gsw attempted suicide - tried gunshot. admits to b/hess tonight.

TREATMENT PRIOR TO ARRIVAL: ☒ None
Medication: _____ Time _____
Other: _____
Prehospital Care:
☐ None ☐ Ice ☐ Elevate
☐ Spinal Immob. ☐ Splint _____
☐ C-Collar ☐ IV _____
☐ Dressing _____ ☐ O_2 _____

PAST MEDICAL HISTORY ☐ Non-significant PMH ☐ AMI Date _____ ☐ CHF
☒ HTN ☐ CABG ☐ CAD ☐ ASCVD ☐ Diabetes ☐ PUD
☐ CRF ☐ COPD ☐ Asthma ☐ Sz Disorder Use ☐ Arthritis ☐ Ca
☐ CVA ☐ Sickle Cell ☐ HIV ☐ Hepatitis ☐ Liver Disease
☐ Migraine ☒ Other: Mental
Weight 180 ☒ Tobacco use 1ppd ☒ Alcohol use occasion

ALLERGIC TO DRUG ☐ YES ☒ NO LIST: _____
FOOD ☐ YES ☒ NO LIST: _____

PRESENT MEDICATIONS NONE ☐ SEE HOME MED SHEET ☐ SEE NURSING HOME LIST ☐

Tetanus ☐ U.T.D. ☐ unknown ☒ > 5 years

VITAL SIGNS

Time	Pulse	Resp.	B/P	Temp T R O	Pulse Ox
	123	20	176/113	98	

ASSESSMENT

RESPIRATORY
☐ Not applicable
☒ Normal bilateral
☐ labored
☐ rales/rhonchi
☐ wheezing R L
☐ retractions
☐ nasal flaring
☐ decreased R L
☒ Cough
☐ non-productive
☐ productive
☐ sputum color: ____
☒ airway clear
☐ part. obstructed
☐ obstructed

CARDIO-VASCULAR
☐ Not applicable
☒ Pulse regular
☐ irregular
☒ Skin W & D
☐ cool & clammy
☒ Skin pink/normal
☐ pale
☐ cyanotic
☐ flushed
☐ jaundiced
☐ rash
☒ Cap refill <2 sec.
☐ >2 sec
☒ Pulses intact
☐ Edema
☐ JVD

GASTROINTESTINAL
☐ Not applicable
☒ Bowel sounds present
Abdominal
☒ Soft ☐ Firm
☐ Nondistended ☐ Distended
Abdominal Tenderness
☐ Yes ☒ No
☐ Rebound Last BM _____
Diarrhea ☐ Yes ☒ No
Vomiting ☐ Yes ☒ No

GENITOURINARY
☐ Not applicable ☐ Dysuria
☐ Frequency ☐ Discharge
☐ Swelling
☐ Hx/Bleeding _____
☐ LNP _____

HYDRATION STATUS
☐ Not applicable
Mucous Membranes:
☒ Moist ☐ Dry
Eyes
☒ Normal ☐ Sunken
Skin Turgor:
☐ Poor ☒ Normal

FONTANELLES ☐ N/A > 19 mon
☐ flat ☐ bulging
☐ depressed

GROWTH & DEVELOPMENT
Personal-Social ☐ WNL no
Fine Motor ☐ WNL no
Language ☐ WNL no
Gross Motor ☐ WNL no

PEDIATRIC IMMUNIZATION:
☐ UTD
☐ NUTD*
Head Circum.: _____
☐ N/A > 36 mon
Birth Weight _____

SKIN/EXTREMITY
☒ Not Applicable
☐ Wound/Injury (Describe)
_____
_____
_____

Fall Precaution: ☐ Yes ☒ No
Green Armband On: ☐ Yes ☒ No
At Risk for Skin Breakdown: ☐ Yes ☒ No
Advance Directive ☐ Yes ☒ No
DNR ☐ Yes ☒ No

NEUROLOGICAL
☐ Not applicable
☒ cooperative
☐ uncooperative
☐ agitated/combative
☒ oriented
☐ disoriented
☒ inappropriate
☐ sleeping
Recorded LOC ☐ Y ☐ N
Min: _____
☐ alert/playful
☐ crying
☐ irritable

Neck
☐ Not Applicable
☐ Supple
☐ Other _____

Pupils
☐ Not Applicable
Acuity
_____ R _____ L
_____ mm Size _____ mm
_____ Brisk _____
_____ Sluggish _____
_____ Fixed _____

NEUROLOGICAL GLASGOW COMA SCALE
Eyes 4
Verbal 5
Motor 6
TOTAL 15

PUPILS (mm) KEY
• 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8

PAIN ASSESSMENT

☐ NONE ☒ CURRENTLY HAVE PAIN ☐ PAIN IN LAST 6-8 WEEKS
LOCATION: Back
ONSET: 1991 QUALITY: Stab ☒ CONSTANT ☐ INTERMITTENT
WHAT HAS RELIEVED YOUR PAIN? PAST: _____ CURRENT: nothing
CURRENT PAIN LEVEL: NEONATE (0-10) _____ INFANT/CHILD (0-5) _____ ADULT (0-10) 8

Pain Intensity (VAS or FACES)

VAS
Rate Pain and effectiveness on scale 0 = no pain & 10 = worst pain

0 NO HURT	1 HURTS LITTLE BIT	2 HURTS LITTLE MORE	3 HURTS EVEN MORE	4 HURTS WHOLE LOT	5 HURTS WORST

0 1 2 3 4 5 6 7 8 9 10

NUTRITION SCREEN

☒ No Apparent Problem ☐ Teeth Intact ☐ Missing Teeth ☐ Toothless
☐ Poor Appetite ☐ Emaciated Appearance ☐ Obese Appearance ☐ Unintentional Weight Loss (>10 lbs. in last 3 months)
☐ Pregnancy ☐ Lactating ☐ Anemia ☐ Eating Disorder

FUNCTIONAL SCREEN

☐ Difficulty performing ADLS without assistance or special aid/s: None
☐ Problems with balance or mobility None
☐ Difficult speech; chewing or swallowing problems ☐ Visual Impairment

ASSESSMENT KEY

	INFANT / TODDLER (GCS) GLASGOW COMA SCALE		CHILDREN / ADULT GLASGOW COMA SCALE	
EYE OPENING	SPONTANEOUS	4	SPONTANEOUS	4
	TO SPEECH	3	TO VOICE	3
	TO PAIN	2	TO PAIN	2
	NONE	1	NONE	1
VERBAL RESPONSE	SMILES, INTERACTS	5	ORIENTED	5
	CONSOLABLE	4	CONFUSED	4
	CRIES TO PAIN	3	INAPPROPRIATE WORDS	3
	MOANS TO PAIN	2	INCOMPREHENSIBLE WORDS	2
	NONE	1	NONE	1
MOTOR RESPONSE	NORMAL, SPONT. MOVEMENT	6	OBEYS COMMAND	6
	LOCALIZES PAIN	5	LOCALIZES PAIN	5
	WITHDRAWS TO PAIN	4	WITHDRAWS TO PAIN	4
	ABNORMAL FLEXION	3	FLEXION (PAIN)	3
	ABNORMAL EXTENSION	2	EXTENSION (PAIN)	2
	NONE	1	NONE	1

☐ SEE TRAUMA FLOW SHEET ☐ SEE CODE SHEET

Triage [signature] R.N.

WBMC-6300-02-WALLACE

PSYCHOSOCIAL STATUS / EDUCATION

Are there any religious, traditional, ethical or cultural practices that need to be a part of your care?

☐ Yes ☒ No

Specify: _____

Are you being hit, hurt or frightened by anyone in your home life?

☐ Yes ☒ No

How do you learn best? ☑ Verbal ☐ Reading ☑ Demonstration

What interferes with your learning? ☐ Physical ☐ Age Related ☐ Communication ☐ Language

☐ Spiritual ☐ Cultural ☐ Hearing ☐ Visual ☐ None ☐ Religious

INTERVENTIONS

☐ Tylenol _____ mg. Time _____

☐ Ibuprofen _____ mg. Time _____

☐ Wound Cleansed _____

_____

☐ NPO - Explained at Triage

☐ C-Collar

☐ Dressing _____

_____

_____

☐ Ice & Elevation

☐ Immobilization

☐ Isolation Mask

CONSENT AND AUTHORIZATION

I am presenting myself for diagnosis and treatment at the Walker Baptist Medical Center and I consent to the rendering of such care, including diagnostic procedures, surgical and medical equipment, and blood transfusions, by authorized members of the hospital medical staff or their designees, as may in their professional judgement be necessary. I acknowledge that no guarantees have been made to me as to the results of such examinations or treatment on my condition.

Undersigned hereby authorizes the Walker Baptist Medical Center and my Physician(s) to release to my insurors full information (including copies of records) relative to this hospitalization.

X _____

PATIENT/PARENT/RESPONSIBLE PARTY SIGNATURE

_____

RELATIONSHIP TO PATIENT

observer
NIR

BARRON **TOMMY**
SOUTHERN MEDICAL GRO 11/11/02
MR: **0246796** M W 045 [redacted]
PT: **9539218-9** CAE FC: L ED 02

(Addressograph)

WALKER
BAPTIST MEDICAL CENTER

CONDITIONS OF ADMISSION
CONSENT FOR TREATMENT
AND FINANCIAL RESPONSIBILITY

CONSENT FOR HOSPITAL SERVICES: Consent is given to Walker Baptist Medical Center, Radiology Associates of North Alabama, P.C., Southern Medical Group, Inc., Foothills Anesthesia P.C., and Baptist Health Clinics, its contractors and its employees to provide hospital services and administer physician orders. Certain procedures may require separate consents. Physicians are responsible for explaining medical or surgical procedures. The undersigned authorizes observers to be present during treatments/surgery for purposes of medical training and education.

PERSONAL VALUABLES: The Walker Baptist Medical Center is not responsible for money, jewelry, dentures, hearing aids, eye glasses, watches, credit cards, and such other items which are not deposited in the Hospital safe.

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorizes the Walker Baptist Medical Center and any physician rendering service, for example, Radiology Associates of North Alabama, P.C., Southern Medical Group, Inc., Foothills Anesthesia, P.C., and Baptist Health Clinics, Inc., to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payors, including the third-party payor's agent and/or representative or anyone responsible for payment of hospital and/or physician charges.

ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorizes direct payment of benefits (including insurance benefits, otherwise payable with respect to the patient) to the Walker Baptist Medical Center, Southern Medical Group, Inc., Radiology Associates of North Alabama, P.C., Foothills Anesthesia P.C., and Baptist Health Clinics, Inc. The undersigned agrees to assist in processing claims for benefits.

MEDICARE AUTHORIZATION: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administrator or its Intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of the authorized benefits be made on my behalf to the Walker Baptist Medical Center, Southern Medical Group, Inc., Radiology Associates of North Alabama, P.C., Foothills Anesthesia P.C. and Baptist Health Clinics, Inc. or any physician rendering service during my treatment.

PHYSICIANS: Physicians including, without limitation, Southern Medical Group, Inc., Radiology Associates of North Alabama, P.C., Foothills Anesthesia, P.C., and Baptist Health Clinics, and Inpatient Medical Services.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay for hospital services, accommodations and physician services rendered to patient and is hereby obligated to pay the account of the hospital. It is understood that in the event of obstetrics care the undersigned is obligated to pay the hospital account for mother and infants(s). It is understood and agreed that Walker Baptist Medical Centers charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable cost of collection including attorney fees, collection agency fees, and/or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned agrees to pay all hospital charges not paid in full to the hospital by a third-party payor. The Walker Baptist Medical Center accepts cash, MasterCard, Visa, Discover Card and Hospital Financial Assistance loan program as forms of payment.

The undersigned is aware that in some cases the patient's hospital bill may not be covered in full by the insurance company. The undersigned is aware of the fact the (patient/responsible party/guarantor) are responsible for any balance insurance does not pay. This balance due may include provisions set by your insurance company such as: co-payments, deductibles, and "usual and customary" allowances. Co-payments, and deductibles are due upon admission and must be paid prior to discharge.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT.

Guarantor (Agreement to Pay)

Witness (to Guarantor Signature)

11/12/02
Date

Patient (or authorized Representative/Relationship to Patient)

Witness (if anyone other than patient signs)

11-12-02
Date

CONDITIONS OF ADMISSION AND CONSENT FOR TREATMENT